Vermont Health Care Innovation Project
Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: June 17, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Roll Call, & Agenda Review	Karen Hein called the meeting to order at 2:32pm. A roll call attendance was taken and a quorum was present. Karen Hein reviewed the meeting agenda.	
2. Approval of Minutes	Penrose Jackson moved to approve the May 12, 2015, minutes by exception. Jill Berry Bowen seconded. The minutes were approved with one abstention.	

3. Accountable Communities for Health	Leslie Mikkelson and William Haar (Prevention Institute) presented on early findings from their study of Accountable Communities for Health, funded by VHCIP through a contract with the State of Vermont. (See Attachments 3a and 3b)
	
	• Health is influenced by a variety of factors (including medical care, but also social factors, environment, health behaviors, and more), and can be impacted by interventions on multiple levels (individual, health care provider, community, policy, etc.).
	• Accountable Communities for Health (ACH): Encompassing medical care, behavioral health/social services, and community-wide prevention. ACHs include all residents of a geographic area, not just a provider's panel of patients.
	
	• Prevention Institute reviewed five ACH exemplar sites across the country. Top level findings:
	  ○ ACHs are aspirational – no community in Prevention Institute's national scan has achieved this across all core elements.
	  ○ Not yet seeing savings shared back into community and prevention
	  ○ Integrator/leader essential for brokering
	  ○ Communications vital to engage partners	

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	• PI identified six key elements: Integrator; Partnership; Assessment, Planning, and Comprehensive Strategies; Data, Metrics, and Accountability; Community Resident Engagement; Funding and Sustainability.
	  ○ Integrator: Can also be Coordinator/Collaborative Leader. Provide key staff functions, build trust among collaborators, hold vision, hold collaborators accountable.
	  ○ Partnership: Provide structure. Most include community prevention/public health; exemplar communities have varied requirements for participation.
	  ○ Assessment, Planning, and Comprehensive Strategies: Assessment, planning, and strategies spanning spectrum of prevention, from individual to provider to community to policy/legislation. In exemplar communities, health education strategies were often emphasized while community prevention is less well represented. In one exemplar community, four key organizations work together to produce a jointly authored Community Health Improvement Plan.
	  ○ Data, Metrics, and Accountability: Data sharing is key to support community assessment, planning, and continued assessment of progress toward goals. In exemplar communities, use of data varies – it is most often one-way data flowing from public health (often County-led) to partner organizations, but some have data flowing from providers back to integrator organization, and others are using GIS mapping of health data as a tool to spur community action.
	  ○ Community Resident Engagement: Ensuring resident/community member participation in strategy development and priority-setting.
	  ○ Funding and Sustainability: Many exemplar communities are grant funded or funded by local/county government; however, some receive a portion of provider taxes or other sources to fund a prevention fund or similar. Some leverage existing funds or receive in-kind support in the form of staff from local agencies. None are reinvesting health care savings to fund integration, prevention work or community-wide strategies.
	
	• The PI team visited four Vermont communities and interviewed two by phone to support this study: Franklin and Grand Isle Counties (Rise VT/Northwestern Medical Center); Northeast Kingdom (Northeastern Vermont Regional Hospital); Chittenden County (Regional Planning Commission); Windsor (Mt. Ascutney Hospital and Health Center); Upper Valley (ReThink Health); and Brattleboro (Brattleboro Memorial Hospital).
	  ○ Hospitals are playing a central role – this is a unique feature of Vermont. Vermont's hospitals show a deep commitment to mission and improving population health which is not always present elsewhere, though hospitals are beginning to move in this direction gradually. Partners are diverse and include social services and other community organizations.
	  ○ Strategies primarily individual and group health education + expanding services
	  ○ Key Building Blocks in Vermont: Communities organizing around ACH; small size; community action to support healthy environments; Blueprint for Health/CHTs; hospital leadership.	

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	• Issues for Reflection:
	  ○ How to address the intersection of health care and service providers (individual focus) with community-wide prevention (community focus)? Need to weave this together to make mutually beneficial. Ideally, these needs and perspectives are balanced – right now, weighted toward improving service delivery and integration at the individual level, less focused on community prevention. Will these be combined or work in parallel? How to structure and fund ACHs in a way that supports local coalition building rather than disrupting local collaboration and trust?
	• Opportunities:
	  ○ Seed funding to support building ACH.
	  ○ Ensure a strong role for community prevention: Could be part of a statewide/comprehensive population health framework; metrics that emphasize community-level/environmental factors (ex/feet of sidewalk per capita; average miles to a grocery store with healthy food); support local leadership development.
	  ○ Develop practices to maximize synergy between integrated services and community prevention (PI's Community-Centered Health Home model).
	  ○ Dedicated funding for prevention.
	  ○ Closing the loop: Capturing savings from prevention (ex/tobacco taxes) to fund community collaboration and prevention.
	
	The group discussed the following:
	• Community mobilization: A wellness model could resonate with many in Vermont. (Jesse de la Rosa)
	• This presentation identifies some things already occurring in Vermont communities, but also identifies areas for improvement. The final report will include detailed case studies. (Laural Ruggles)
	• What level of analyses? The report will summarize current activities – not a deep dive. (Peter Cobb)
	• RiseVT is a partnership with the community and local businesses. The other piece to the partnership is the Regional Clinical Performance Committee (RCPC), which brings together providers and others to undertake quality improvement projects. These might need to merge or integrate further to support population health optimally, though there is great work being done. (Jill Berry Bowen)
	• Described a prevention initiative that supported goal setting, regional dashboards, and a Well-Being of Vermonters framework (from the 1990s) – these have provided a basis for the Green Mountain Care Board dashboards and Agency of Human Services results-based accountability initiatives. (Ted Mable)
	• This morning, a community meeting to discuss community assets to support population health. (Penrose Jackson)
	• Interested in learning more in how the RCPCs/UCCs form and put their resources behind projects (Miriam Sheehey). At least one of the regional teams is working on a community prevention project as part of their RCPC/UCC (Middlebury).
	• How critical are financial models that support providers across the community? (JoEllen Tarallo-Falk)	

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	Karen Hein responded that this is the elephant in the room.
	• Are there data systems that are supporting data sharing across communities? Desire for common local metrics (Steve Voigt) PI did find some of these and will share that information.
	• Where does school health fit in? (JoEllen Tarallo-Falk) RiseVT has schools as a key partner and has developed a scorecard for individuals, families, schools, communities with strategies to support healthy lifestyles. RiseVT is also a VHCIP Sub-Grantee. Also, launched a wellness clinic to support health education for high-risk patients through Northwestern Medical Center. (Jill Berry Bowen)
	  ○ Health education is a key feature of the national exemplar communities as well.
	• Slide showing intersection of two paradigms is helpful – lots of work now through VHCIP to encourage intersection of health care and community/social services (Integrated Communities Care Management Learning Collaborative), but it's critical to include community prevention and environmental strategies as well. (Pat Jones)
	• One of PI's key tasks is to share building blocks already in place in Vermont that support movement toward ACH model (like Blueprint, RCPCs/UCCs) – are there building blocks we and PI have missed? (Heidi Klein)
	  ○ Financial model – it would help to see what we need to think about to finance this. (???)
	  ○ Medicaid ACO contracts as a vehicle for population health. (Sue Aranoff)
	  ○ Hospital community benefit requirements – especially since UCCs are by Health Service Area and OneCare includes most hospitals in the state, this could be something to build on. (Sue Aranoff) GMCB is working to compile Hospital Community Needs Assessments – hospital community benefit investments are now required to be linked to needs assessments. (Karen Hein)
	  ○ Vermont's small hospitals need to be making investments aligned with community health needs. (Laural Ruggles)
	  ○ Work is happening fast! Suggests that savings be funneled back to work with youth since those investments can lead to additional savings. (Chuck Myers)
	
	Karen Hein: The Population Health Work Group leadership team will be reviewing this information and progress to date as it looks to Year 3. Please share any additional building blocks with Leslie and Will (email addresses included in slide presentation).	

4. Next Steps	**Next Meeting:** Tuesday, July 14, 2015, 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier	